TO: MICHIGAN HOUSE JUDICIARY COMMITTEE:

OCTOBER 24, 2013

Regarding: DEATH OF OUR SON CARSON KAPLAN SHARP

(16 MONTHS OLD)

Rebecca Marie Sharp, PR Estate of Carson Kaplan Sharp, Deceased

Formerly a resident of Dearborn Heights Michigan

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PREVIOUSLY REPRESENTED BY

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To the members of the House Judiciary Committee:

As far as we knew, our first son, Carson Kaplan Sharp, was a happy, healthy 16 month little boy that we loved with all our hearts before we took him to a major hospital emergency room that advertised its emergency room as a dedicated pediatric emergency facility. Carson died that day while on a helicopter flying from this hospital to a major medical center in Ann Arbor. We couldn't be with him when he died as we were rushing from Dearborn to Ann Arbor to meet the helicopter.

Carson didn't look right that morning so we took him to the Pediatric Emergency room. There, they drew blood and took tests. They never figured out what was exactly wrong with Carson so they called for the helicopter for transfer to Ann Arbor Michigan. Now, with the help of our lawyer, we know what killed Carson. Carson had an easily

treatable kidney outlet blockage that could have been fixed. Carson could have had a normal life. Because Carson's kidney was not working the potassium level in his blood went up to dangerous levels causing him symptoms that we noticed that day. Although the abnormal potassium level was clearly displayed on the lab results at the emergency room, nobody took the time to read the laboratory results. When the helicopter with doctors and nurses arrived they were given the lab results too but, again, nobody took the time to read them. In mid- flight Carson's heart began to beat abnormally due to the high potassium levels in his blood caused by his treatable kidney condition. The life flight crew decided to put a tube in Carson's windpipe so they could make him more stable. To relax him for the tube they gave him a drug that contains a BLACK BOX WARNING from the FDA and the manufacturer that states it should never be used when the patient has elevated potassium because it can stop the patient's heart. Shortly after the drug was injected, our lovely Carson's heart stopped forever. When we got to Ann Arbor and lerned that Carson did not survive the flight, we asked why, but nobody would tell us what took his life and there was no mention of the drug or the potassium level by the doctors there or in the autopsy report written weeks later by a pathologist at the same hospital that reviewed the entire case. Our lawyer discovered what killed Carson when he ordered and reviewed Carson's medical records. Without a lawsuit, we would have never known what took our son's life. It took a lawyer to find out who killed our son. The doctors did not tell us.

I was so depressed that we could not have a jury decide what appropriate damages were for this careless, avoidable death of the loveliest little boy you can imagine; our little boy. The Defendants made a settlement but the damages were capped by law and after three years of litigation and after reduction for costs of litigation and attorneys fees and after the funds were divided up among our family that knew and loved Carson, we were left with very little other than our grief. We needed tell our story. I thought this was America and that a right to trial by jury was a right every American had. Our founding fathers saw to it that we got this right but the Michigan legislature took it away when they capped damages and passed tort reforms in 1986 and again in 1993/1994. My lawyer tells me that now the doctors and insurance companies are coming back for more tort reform; reforms that will eliminate medical

malpractice cases like Carson's that involve emergency room treatment. It was so horrible and insulting being told by some law-maker, lobbyist, or insurance company representative, what the value of our son's life was without even knowing him or meeting him or our family. I can only imagine how horrific it would have been if we could not have sued at all because the doctors had been given immunity by the legislature. I can tell you that like many other couples who have lost a child, we have gone on to divorce; but our grief continues and will last our entire life. We were devastated when Carson was taken by the negligence of the emergency room doctor and the life flight staff, and injured again by the tort system in this state. Please do not limit the rights of malpractice victims any further.

Rebecca Sharp, Mother of Carson Kaplan Sharp, deceased.

Statement of Gregory M Bereznoff:

THE EFFECT OF TORT IMMUNITY

Further extension of tort reform provisions in the State of Michigan is unwarranted. (Please see the memorandum of Norman Tucker, Esq., which dispels each and every alleged justification for further tort reform in this arena) Implementing a statute that effectively immunizes emergency room personnel and downstream caregivers from liability will do absolutely nothing for patient safety. If the members of this committee recognize and value the rights of the citizens of the state of Michigan to be free from harm, and believe in the concepts of accountability and justice for citizens injured by medical errors, the statutes now before the committee must be rejected.

This committee should be informed by measures taken in other fields involving both complexity and CRUCIAL safety concerns, which effectively promote safety and accountability. I am referring to the Federal Aviation Administration and its oversight of the airline industry. When an airliner crash occurs, the victims of the crash are not vilified nor are the wrongdoers protected and immunized from liability. Rather, the FAA model involves immediate investigation of each incident with implementation of a process that runs to ground the root cause for each and every incident such that policies and procedures may be implemented to ensure that the mechanism of incident

and injury has been identified and eliminated as a cause of future incidents. It is largely due to the policies and procedures utilized by the FAA that the airline travel has become the safest method of travel in this and other countries.

This committee can understand that it would make absolutely no sense whatsoever to promote safety in the airline industry by eliminating the rights of passengers to bring suit against culpable parties or individuals who caused an airline incident resulting in death or injury. It would make even less sense to fail to investigate the root cause for each and every incident. It would be completely irresponsible to fail to address known patterns of incident and injury with appropriate policies and procedures.

Yet, this is the precise policy urged upon this committee by the proponents of the current immunity bill. Instead, the FAA model should be applied to medical errors. This committee should focus upon policies and procedures that run to ground the causes of frequently encountered medical errors and the implementation of policies and procedures to prevent their recurrence. In this manner, the root cause of medical errors causing death or injury can be addressed in the most functional manner possible for all parties concerned.

Instead of documenting and addressing the causes of medical errors, limiting liability and shielding medical caregivers from accountability will have the exact opposite effect. Without the potential for accountability the incentive to investigate and eliminate current patterns of medical errors will largely be removed. We need to allocate significant resources to the systematic documentation of and elimination of known patterns of medical errors. If the current emergency room immunity bill is passed, the most basic incentive to invest in safety in the emergency room will be removed.

INCIDENCE OF MEDICAL ERRORS

The Congressional Budget Office (CBO) found that there were 181,000 severe injuries attributable to medical negligence in 2003.[3] The Institute for Healthcare Improvement estimates there are 15 million incidents of medical harm each year.[4] HealthGrades, the nation's leading healthcare rating organization, found that Medicare patients who experienced a patient-safety incident had a one-in-five chance of dying as a result.[5]

Researchers at the Harvard School of Medicine have found that even today, about 18 percent of patients in hospitals are injured during the course of their care and that many of those injuries are life-threatening, or even fatal.[6] The Office of the Inspector General of the U.S. Department of Health and Human Services found that one in seven Medicare patients are injured during hospital stays and that adverse events during the course of care contribute to the deaths of 180,000 patients every year.[7]

Recently the Joint Commission Center on Transforming Healthcare reported that as many as 40 wrong site, wrong side and wrong patient procedures happen every week in the U.S.[8] Similarly, researchers in Colorado recently found that surgical "never" events, such as operating on the wrong patient or wrong site or performing the wrong procedure, are occurring all too frequently[9]

Yet despite these numbers, the American public remains unaware of just how pervasive the problem is.

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[1] To Err Is Human: Building a Safer Health System, Institute of Medicine, 1999
[2] Deaths/Mortality, 2005, National Center for Health Care Statistics at the Centers for Disease Control, viewed at http://www.cdc.gov/nchs/fastats/deaths.htm.
[3] Key Issues, Congressional Budget Office, December 2008, 150-154.
[4] Institute for Healthcare Improvement: Campaign – FAQs, Institute for Healthcare Improvement, http://www.ihi.org/IHI/Programs/Campaign/Campaign.htm?TabId=6.
[5] The Fifth Annual HealthGrades Patient Safety in American Hospitals Study, HealthGrades, April 2008.
[6] Christopher P. Landrigan et al., Temporal Trends in Rates of Patent Harm Resulting from Medical Care, New England Journal of Medicine, November 25, 2010.
[7] Daniel R. Levinson, Adverse Events in Hospitals: National Incidence Among Medicare Beneficiaries, Department of Health and Human Services Office of the Inspector General, November 2010.
[8] Wrong Site Surgery Project, Joint Commission Center for Transforming Healthcare.

[9] Philip F. Stahel et al., Wrong-Site and Wrong-Patient Procedures in the Universal Protocol Era, Archives of Surgery, 2010;145(10):978-984.

[10] National Survey on Consumers' Experiences With Patient Safety and Quality Information, Kaiser Family Foundation, November 17, 2004.

[11] Tom Baker, The Medical Malpractice Myth, 2005.

[12] Those medical complications not covered were: Object Left in Surgery (Serious Preventable Event); Air Embolism (Serious Preventable Event); Blood Incompatibility (Serious Preventable Event); Catheter-Associated Urinary Tract Infections Pressure Ulcers (Decubitus Ulcers); Vascular Catheter-Associated Infection Surgical Site Infection Hospital Acquired Injuries, including fractures, dislocations, intracranial injury, crushing injury, and burns. See 72 F.R. 47201.